# MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043888

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. 6314 STATE FILE NUMBER

DO NOT WRITE ON THIS STUB — AMENDED

VS 300 Rev. 4/59

FILED DEC 11 1963

1. PLACE OF DEATH
a. COUNTY: Jackson
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: Kansas City
Length of stay in 1b: 36 yrs.
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: Lindeman Nursing Home
Inside Limits: Yes [X] No [ ]

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Jackson
c. CITY OR TOWN: Kansas City
Inside Limits: Yes [X] No [ ]
d. STREET ADDRESS (If outside, give location): 304 West 34th. St.
Reside on Farm: Yes [ ] No [X]

3. NAME OF DECEASED (Type or print): First FRANCES Middle G Last EACOCK

4. DATE OF DEATH: Month November Day 21 Year 1963

5. SEX: Female

6. COLOR OR RACE: White

7. Married [ ] Never Married [ ] Widowed [ ] Divorced [X]

8. DATE OF BIRTH: 4-9-1897

9. AGE (last birthday): 66
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Registered Nurse

10b. KIND OF BUSINESS OR INDUSTRY: Leed's Tuberculer San.

11. BIRTHPLACE (City and state or country): Wray, Colorado

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: Andrew Hoy

13b. MOTHER'S MAIDEN NAME: —

14. NAME OF HUSBAND OR WIFE: none

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of servi: no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. James Eacock Address: Minneapolis, Minn.

18. CAUSE OF DEATH (Enter only one cause per line
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 da
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b): Metastatic Carcinoma of
DUE TO (c): Esophagus — 4 mo

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. [ ] Yes [ ] No [ ] Unknown

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT [ ] SUICIDE [ ] HOMICIDE [ ]

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from July 1963, to Death and last saw her alive on 11/20/63
Death occurred at 12:10 a m on the date stated above, and to the best of my knowledge, from the causes stated.

MEDICAL CERTIFICATION — William D. Hoadley

22a. SIGNATURE (Degree or title): William D. Hoadley MD

22b. ADDRESS: 6400 Prospect

22c. DATE SIGNED: 11/22/63

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE: 11-23-63

23c. NAME OF CEMETERY OR CREMATORY: Calvary Cemetery

23d. LOCATION (City, town, or county) (State): St. Mary's, Kansas

24. FUNERAL DIRECTOR ADDRESS: Mellody-McGilley-Eylar 20 W. Linwood

25. DATE RECD. BY LOCAL REG.: 11-21-63

26. REGISTRAR'S SIGNATURE: Bessie Smith

(Licensed Embalmer's Statement on Reverse Side)

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

| ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED |
|---|---|---|---|
| 2 | 3478 | 2 | |
| 4 | 1 | | |
| 5 | 3 | | |
| 7 | 1 | | |
| 8 | 2 | | |
| 9 | 150X | | |
| 12 | 86-0 | | |

BY AFFIDAVIT OF DOCUMENT

USE BLACK INK OR TYPEWRITER RIBBON

Dr. Wm. D. Bradley
6400 Prospect
Em 3-2288

Thurs: 1:00 To 5:00

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No._____

working under my personal supervision.

Student_____ Signed_____
Signature of Student Embalmer

Licensed Embalmer No._____

P. O. Address_____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.